PATIENT REGISTRATION

Today's Date: _____ Whom may we thank for referring you? _____

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell: _____ Home: _____ Work: _____ ext:_____

E-mail: _____

Birthdate: _____ Sex: ☐ M ☐ F Soc. Sec._____-_____-_____

Marital Status (necessary for insurance claim filing): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Student Status (necessary for insurance claim filing): ☐ Full Time ☐ Part Time ☐ Not a student

RESPONSIBLE PARTY INFORMATION:

Who is financially responsible for this patient? This is not necessarily the person holding the insurance policy, if any. If the patient is the responsible party, check this box and skip to the next section. ☐

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell: _____ Home: _____ Work: _____ ext:_____

Birthdate: _____ Email: _____ SS#_____-_____-_____

INSURANCE INFORMATION: ☐ Check this box if there is no insurance.

Insured Person: Name _____ Soc. Sec. #:_____-_____-_____ DOB:_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Group #: _____ Other Information on Card: _____

EMPLOYER INFORMATION	INSURANCE COMPANY INFORMATION
Employer: _____	Name: _____
Address: _____	Address: _____
_____	_____
City, State, Zip: _____	City, State, Zip: _____
Phone #: _____	Phone #: _____

☐ If you have secondary insurance, please check this box and speak to the front desk staff.

*** Please be sure to give your insurance card, if applicable, to the front desk staff for photocopying.

- **THANK YOU!** -